



APPLICATION FOR REFUND \$300 SMOG IMPACT FEE

APPLICANT INFORMATION

Please print or type information and mail the completed form to the address below.

Applicant(s) name(s): Last name, first name, middle initial of the individual(s) and/or company that ***paid*** the \$300 Smog Impact Fee.

FULL NAME/COMPANY (LAST, FIRST, MIDDLE INITIAL)

CALIFORNIA VEHICLE DEALER NUMBER (IF APPLICABLE)

FULL NAME/COMPANY (LAST, FIRST, MIDDLE INITIAL)

STREET ADDRESS

CITY

STATE

ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

CITY

STATE

ZIP CODE

PLEASE SHOW NAME(S) OF THE VEHICLE OWNER(S) (IF DIFFERENT THAN THE APPLICANT'S NAME)

CALIFORNIA LICENSE PLATE NUMBER

MAKE

MODEL YEAR

COMPLETE VEHICLE IDENTIFICATION NUMBER (VIN)

To help us process your claim, please provide us with the California license plate number and/or VIN. If this information is NOT provided, it may cause a delay in processing your claim.

Date fees paid _____
DAY MONTH YEAR

The \$300 Smog Impact Fee was paid when this vehicle was registered in California. ☐ Yes ☐ No

CERTIFICATION

I CERTIFY under penalty of perjury under the laws of the State of California that the information I have provided is true and correct.

APPLICANT'S SIGNATURE

CALIFORNIA DRIVER LICENSE NUMBER

DATE



FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) FOR DEALERS OR COMPANIES ONLY

DAYTIME TELEPHONE NUMBER

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MAIL TO: Department of Motor Vehicles
Smog Impact Fee Refund Unit — S
P.O. Box 825391
Sacramento, CA 94232-5391

FOR DMV USE ONLY

Date Received